MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

154 46a 0322

Reg. Dist. No. 77

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (Rural)
HOSPITAL OR INSTITUTION OR STREET ADDRESS
MARYLAND
LENGTH OF STAY (in this place) 40 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (Rural)
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) EMERY (Middle) F (Last) ALBAUGH

4. DATE OF DEATH (Month) Jan (Day) 26 (Year) 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M

8. DATE OF BIRTH June 10 1885

9. AGE last birthday 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Dallas Albaugh

14. MOTHER'S MAIDEN NAME Lydia E Lester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Mrs Deborah J Rote

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia	3 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Urinary Obstruction (Prostatic urethra)	1 year
	(c) Carcinoma of Rectum	3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1945

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Rectum

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1945, to Jan 26, 1949, that I last saw the deceased alive on Jan 25, 1949, and that death occurred at 26 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Maurice C. Porterfield ADDRESS Hampstead, Md DATE SIGNED 1-26-49

23. BURIAL, CREMATION REMOVAL (Specify) DATE Jan 29/49 NAME OF CEMETERY OR CREMATORY Hampstead LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Jan 28, 1949 REGISTRAR'S SIGNATURE John S. Hughes Jr

24. FUNERAL DIRECTOR Edw C Tipton ADDRESS Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 29 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0323

002
126

CERTIFICATE OF DEATH

Reg. Dist. No. 35-75

1. PLACE OF DEATH:

County Carroll

City or town Millers (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? - 10 yrs

Hospital, Institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Millers (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Evelyn Pauline Asper

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Jacob E Asper

6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.): Feb. 10 - 1924

8. AGE: Years 24 | Months 11 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Edward Paul Mustin Sr
13. Birthplace Pittsburg, Pa

MOTHER
14. Maiden name Clara Estella Shearer
15. Birthplace Carroll County, Md.

16. Informant Jacob Asper
Address Millers, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 1-27-49 (month) (day) (year)

Cemetery or crematory Cemetery

Location St Peters Baltimore Co.

18. Funeral director Jacob Winks Sons
Address Manchester, Md

19. Jan 25 1949 Charles L Fulton Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1949 at 3:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to Jan 24 1949 and that I last saw her alive on Jan 24 1949

Immediate cause of death: Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION: 4 yrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Foard M. D. or other

Address Manchester, Md Date signed Jan 24-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

175 / 0324

49a

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Carroll COUNTY Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MAMIE (Middle) E (Last) BAKER

4. DATE OF DEATH (Month) Jan (Day) 21 (Year) 1949

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH Sept 17-1884 | 9. AGE last birthday 64 yrs. | If under 1 year Months. 4 Days 4 | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY ✓ | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John M Reese | 14. MOTHER'S MAIDEN NAME Mary J Cullison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No | 16. SOCIAL SECURITY NO. ✓ | 17. INFORMANT Nowille Baker.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Partial Intestinal Obstruction	3 mo
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Left Ovary	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Nov. 1948 | 19b. MAJOR FINDINGS OF OPERATION Carcinoma of L. Ovary; Advanced Metastasis | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1948, to Jan. 21, 1949, that I last saw the deceased alive on Jan. 20, 1949, and that death occurred at 6:15a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Maurice C. Porterfield M.D. | Hampstead Md | 1-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Jan 22/49 | NAME OF CEMETERY OR CREMATORY Wesley Meth. | LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Jan. 22, 1949 | REGISTRAR'S SIGNATURE John S. Hughes, Jr. | 24. FUNERAL DIRECTOR Edward Tipton | ADDRESS Hampstead Md

RECEIVED
JAN 25 1949
BUREAU T. R.

0325

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

002
13b

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town rural, near Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. New Windsor Road
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME James Garfield Barnes

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife Florence Whitehill Barnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1880

8. AGE:

Years	Months	Days	If less than one day
68	2	14	..... hrs. ..... min.

9. Birthplace Uniontville Fred Co. Md.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER
12. Name Cephas Barnes
13. Birthplace Fred Co. Md.

MOTHER
14. Maiden name Annie Warner
15. Birthplace Fred Co. Md.

16. Informant Miss Erma Barnes

Address Westminster, Md. (New Windsor road)

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/49 (month) (day) (year)

Cemetery or crematory Singamore Cem.

Location near Uniontville Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 1/3 1949 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1949 at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1948, to Jan 3 1949 and that I last saw him alive on Jan 3 1949

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Merritt E. Robertson M. D. or other

Address New Windsor, Md Date signed 1/3/49

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

0326

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (in this place) since 5/14/48; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY ~~Balto.~~; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN --- Baltimore; STREET ADDRESS (If rural, give location) 3002 Clifton Avenue

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Ross (Last) BLAKE

4. DATE OF DEATH: (Month) January (Day) 21 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 7/13/1880

9. AGE last birthday: 68 yrs. If under 1 year: Months. — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laboratory work

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Winchester, Va.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: George Ross Blake

14. MOTHER'S MAIDEN NAME: Alice Sherwood Freeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If year, give war or dates of service): ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval between onset and death: 3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ---

(c) ---

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis, Parkinson's syndrome, arrested pulmonary T.B. — 5 years

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ---

(CITY OR TOWN): ---

(COUNTY)

(STATE)

TIME OF INJURY (Month) --- (Day) --- (Year) --- (Hour) --- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Nov. 9, 1948, to Jan. 20, 1949, that I last saw the deceased alive on Jan. 20, 1949, and that death occurred at 4:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Martin Gross M.D. — ADDRESS: Martin Gross, M. D. Sykesville, Maryland — DATE SIGNED: 1/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1/24/49 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet — LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 1-24-49 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 93d

0327

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M The correct age

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: CARROLL — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL WESTMINSTER — LENGTH OF STAY (In this place): 3 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ROUTE 6

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL WESTMINSTER
STREET ADDRESS (If rural give location): ROUTE 6

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) E. (Last) BRENGLE

4. DATE OF DEATH: (Month) JAN. (Day) 30 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 10/13/1870

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN N. BRENGLE

14. MOTHER'S MAIDEN NAME: ANN R. CROMWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: JOHN W. BRENGLE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis General

(c) Chronic Myocarditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 28 1949, to Jan 30, 1949, that I last saw the deceased alive on Jan 30, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm Clemm Speicher Westminster Md 1/31/49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE: FEB. 2, 1949 — NAME OF CEMETERY OR CREMATORY: MOUNT OLIVET CEM. — LOCATION (City, town, or county): FREDERICK — (State): MD.

DATE REC'D BY LOCAL REG. 1/3/49 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: HARRY R. WEER — ADDRESS: SYKESVILLE, MD.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

932.9 0328 1952

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Sykesville; LENGTH OF STAY (In this place) 24 yr.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Sykesville
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) Springfield State Hospital

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ESTHER		BRENNIMAN	Jan.	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Unknown	6-14-1896	52 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Pennsylvania	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Henry Brenniman	Frances Size

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exposure and exhaustion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Marsh	Deputy Medical Examiner	Westminster Md	Feb. 27-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	Mar. 2, 1949	Springfield Hospital	Sykesville Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 1, 1949	C. Harry Weer	C. H. Weer	Sykesville, Md.

VS. A15

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RECEIVED
MAR 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0329

420.1 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster
LENGTH OF STAY (in this place): LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER — Rural
STREET ADDRESS (If rural, give location): 519 E. MAIN ST. Extd

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) BLANCHE (Last) BRIGHTWELL

4. DATE OF DEATH: (Month) JAN. (Day) 30 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW

8. DATE OF BIRTH: 12/30/1877

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN POWDER

14. MOTHER'S MAIDEN NAME: SARAH HINER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. J. HOWARD STONE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Disease of Coronary Arteries — Interval Between Onset and Death: attacks for past 3 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardio-Vascular Disease — 3 years

(c) with Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from about Jan. 1st, 1946, to Jan. 30th, 1949, that I last saw the deceased alive on Jan. 29th, 1949, and that death occurred at 6:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): J. Billingslea, M.D. — ADDRESS: Westminster, Md. — DATE SIGNED: 1-31-49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 2/1/49 — NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH CEM. — LOCATION (City, town, or county) (State): CARROLL CO. MD.

DATE REC'D BY LOCAL REG.: 1/3/49 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: J. FRANCIS REESE — ADDRESS: WESTMINSTER, MD.

VS. A15

RECEIVED
FEB 1 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

0330

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton; LENGTH OF STAY (in this place): 2 Yrs., 1 Mo., 5 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton Sanatorium	STREET ADDRESS (If rural, give location): 1025 Morris Street ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Gilbert	Bruce	January	7,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
male	colored	Widow	March 13, 1901	47 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Automobile Mechanic		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Henry Bruce	Susie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	June, 1946
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 2, 1946, to Jan. 7, 1949, that I last saw the deceased alive on Jan. 7, 1949 and that death occurred at 6 a.m. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	1/7/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 10/49	St. Louis Cem.	Clarksville Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	Albert R. Swankhamer	Easton Sons Ellicott City Md.	

VS. A15

RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 0331

002 / 13b

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton, LENGTH OF STAY (in this place) 5 mos., 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 23,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton, Sanatorium, Henryton	STREET ADDRESS (If rural, give location) 1020 W. Saratoga Street

3. NAME OF DECEASED (Type or Print)	(First) Archie	(Middle) Thomas	(Last) Clayborne	4. DATE OF DEATH	(Month) January (Day) 29, (Year) 1949
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 23, 1894	9. AGE last birthday 54 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Clayborne			14. MOTHER'S MAIDEN NAME Lula Broadus		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) War I		16. SOCIAL SECURITY NO. 217-09-2921	17. INFORMANT Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	December
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	1947
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1948 to Jan., 29, 1949, that I last saw the deceased alive on Jan., 29, 1949 and that death occurred at 8:30 a. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	Jnauary 29, 1949

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE 2/1/1949	NAME OF CEMETERY OR CREMATORY Mt Arbun City	LOCATION (City, town, or county) (State) Balto M Ld
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE Albert R. Swanthams Deputy Local	24. FUNERAL DIRECTOR Mrs Katie R. Willian 322 N. Schroeder St	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0392

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
STATE: MARYLAND
LENGTH OF STAY (in this place): 2yrs.2mths.28
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton, Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: St. Mary's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mechanicsville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) — (Last) COOPER

4. DATE OF DEATH: (Month) Jan., (Day) 25, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov.,12,1928

9. AGE last birthday: 20 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mechanicsville, Md.,

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Samuel Cooper

14. MOTHER'S MAIDEN NAME: Blanche Shorter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: Aug.,5, 1946

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED Wbile at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct.,28, 1946, to Jan.,25, 1949, that I last saw the deceased alive on Jan.,25, 1949, and that death occurred at 8:40 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. ADDRESS: Henryton, Maryland DATE SIGNED: January 25, 1949

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE: Jan. 29, 1949 NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG.: 1-25-49 REGISTRAR'S SIGNATURE: Albert R. Counihan Deputy Local

24. FUNERAL DIRECTOR: Eugene Ford, 1213-4½ St., S.W. ADDRESS: Washington, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JAN 29 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 0333

CERTIFICATE OF DEATH

93d Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 95 W. Green St

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Irwin (Last) Cunningham

4. DATE OF DEATH: (Month) Jan. (Day) 29 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: 4/2/72

9. AGE last birthday: 76 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Westminster, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Henry Irwin

14. MOTHER'S MAIDEN NAME: Helen Boyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: John H. Cunningham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic myocarditis	1 yr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	4 yrs.
	(c) Anemia Osteoarthritis Spine	4 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1946, to January 29, 1949, that I last saw the deceased alive on Jan 30, 1949, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wilbur Speicher Westminster Md 1/31/49

23. BURIAL, CREMATION REMOVAL (Specify) burial — DATE 2/1/49 — NAME OF CEMETERY OR CREMATORY Westminster Cem. — LOCATION (City, town, or county) (State) Westminster, Md.

DATE REC'D BY LOCAL REG. 1/31/49 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS J. Francis Reese Westminster Md.

RECEIVED
FEB 1 1949
BUREAU V. S.

0334

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

334
83b

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Frederick COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): 2 years, 10 months 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frederick
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural give location): 8 East 2nd Street

3. NAME OF DECEASED (Type or Print)	(First) Anne	(Middle) Virginia	(Last) Eaton	4. DATE OF DEATH	(Month) January (Day) 5, (Year) 1949
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: 6-17-1876	9. AGE last birthday: 72 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: G.H.B. Atchison	14. MOTHER'S MAIDEN NAME: Jennie Toole				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Hospital records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Multiple cerebral embolisms and softening of the brain	about 3 months
Antecedent cause(s)	(b)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cerebral arteriosclerosis	about 9 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-19, 1946, to 1-5, 1949, that I last saw the deceased alive on 1-5-, 1949, and that death occurred at 6.55 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
Irene L. Holshman, M.D	Springfield State Hospital	1-5-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 1/12/49	NAME OF CEMETERY OR CREMATORY: Arlington National Cem	LOCATION (City, town, or county): Arlington	(State): Va.
DATE REC'D BY LOCAL REG.: Jan. 6, 1949	REGISTRAR'S SIGNATURE: C. Harry Weer	24. FUNERAL DIRECTOR: C.E. Cline & Son	ADDRESS: Frederick Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 10 1949
BUREAU V. S.

0385

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

581.1
124a

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, institution, or street address where death occurred:
How long in hospital or institution Various times past year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Elmo

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of ~~husband~~ or wife Dorothy Elmo
6.(c) If alive, give age 31 years
7. Birth date of deceased (mo., day, yr.) July 28 - 1914

8. AGE: Years 34 Months 5 Days 17 If less than one day ..... hrs. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation Restaurant - Proprietor
11. Industry or business Saloon + Meals
FATHER
12. Name Peter Elmo
13. Birthplace Italy
MOTHER
14. Maiden name Martha Loftus
15. Birthplace Balto. Md.
16. Informant Mrs. Dorothy Elmo
Address Finksburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1949 (month) (day) (year)
Cemetery or crematory St. Johns Cemetery
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 1/17 1949 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1949 at 3 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1948 to Jan. 15 1949
and that I last saw him alive on Jan. 14, 1949
Immediate cause of death Alcoholic Cirrhosis Liver
DURATION ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph E. Bush MD
M. D. or other
Address Hampstead Md. Date signed 1-15-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 19 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

0336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): since 8-28-48	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): 1617 Gorsuch Avenue

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Gustauf	Julius	FEIST		January	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	10/4/1863	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Florist	---	Germany	unknown

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
unknown	---	unknown	Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Bronchopneumonia	2 days
Antecedent cause(s)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis	9 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
---	---	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
---	---	---		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
--- m.		---

22. I hereby certify that I attended the deceased from Dec. 22, 1948, to January 7, 1949, that I last saw the deceased alive on Jan. 6, 1949, and that death occurred at 12:05 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Martin Gross, M.D.	Martin Gross, M.D. Sykesville, Maryland	1/7/49

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-10-49	Mareland Park	Balto, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 7, 1949	Nancy Kerr	L. J. Kuck	5305 Harford Rd.

RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0337

002

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Turner Satation- 22-
STREET ADDRESS (If rural, give location): 742 Avondale Road ✓

3. NAME OF DECEASED (Type or Print): (First) FRED (Middle) CLARENCE (Last) FLOOD

4. DATE OF DEATH: (Month) January (Day) 16, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 11, 1913

9. AGE last birthday: 35 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ronoake, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Janme Flood

14. MOTHER'S MAIDEN NAME: Kate Sally

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): W.W. 2

16. SOCIAL SECURITY No.: None

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Oct., 1948

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 18, 1948, to Jan. 16, 1949, that I last saw the deceased alive on Jan. 16, 1949, and that death occurred at 9:20 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. — ADDRESS: Henryton, Maryland — DATE SIGNED: January 16, 1949

23. BURIAL, CREMATION REMOVAL, (Specify): Burial — DATE: Jan. 21 1949 — NAME OF CEMETERY OR CREMATORY: National Cemetery — LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 1-16-49 — REGISTRAR'S SIGNATURE: Albert R. Swankham — 24. FUNERAL DIRECTOR: Mr. George H. Holland and Wife — ADDRESS:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JAN 24 1949
BUREAU U. S.

0338

Evidence for change of age shown on:

FILM No. G 118 JAN 11 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 002 12t

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month 18 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore-18 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2317-Hunter Alley (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Ada Galloway

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Seperated

6.(b) Name of husband or wife: Francis Galloway

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) February 5, 1911

8. AGE: Years 37 ~~31~~ | Months 10 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Clinton, N. Carolina (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Mathew Sampson
13. Birthplace Clinton, N. Carolina

MOTHER
14. Maiden name Maggie Hill
15. Birthplace Clinton, N. Carolina

16. Informant Mrs. Savannah Miller (sister)

Address 1111-Harlem Avenue Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6, 1949 (month) (day) (year)

Cemetery or crematory Pleasant Rest Cemetery

Location Towson, Maryland

19. Funeral director Mrs Geo. H. Holland

Address 1631 Druid Hill Ave.

19. January 2 1949 (Date rec'd by registrar) Albert R. Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1949 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1948 to January 2 1949 and that I last saw her alive on January 2 1949

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 1-2-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

0339

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

924.0
182

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
135 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 W. Main St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Linda Gene Gill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Infant.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 14 - 1948

8. AGE:

Years	Months	Days	If less than one day
	1	22	..... hrs. ..... min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER
12. Name Eugene H. Gill
13. Birthplace Finksburg Md

MOTHER
14. Maiden name Virginia I. Haines
15. Birthplace Westminster Md

16. Informant Eugene H. Gill

Address 135 W. Main St, Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1949 (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster, Md

18. Funeral director H Bankard Son

Address Westminster, Md.

19. 1/5 1949 L K Wadomski
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1949 Prior to at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Suffocation

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1-5-49

Where did injury occur? Westminster (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Suffocated in pillow Injured at work? none

23. SIGNATURE James T. Marsh, Deputy Medical Examiner
M. D. or other

Address Westminster Md Date signed 1-5-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

0340

2411 N. Charles Street, Baltimore

002

CERTIFICATE OF DEATH

13b

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton

LENGTH OF STAY (in this place): 13 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

STREET ADDRESS (If rural, give location): 85 Water St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Viola	Emma	Green	January	20,	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
female	Col.	Sep.	July 7, 1909	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hous wife		Skidmore, Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Harris	Mary Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yr, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
		Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — April

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) — 1948

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from January 7 19 49 to January 20 19 49, that I last saw the deceased alive on January 20, 19 49 and that death occurred at 1:05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Maryland	January 20, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Jan. 24, 1949	Brewer Hill	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
	Albert R. Brumbaugh	William Rose Jr. per Walter A. Carter

VS. A15

RECEIVED
JAN 26 1949
BUREAU V. S.

0341

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

353.3
1952

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural -- Sykesville LENGTH OF STAY (in this place) 30yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-- Sykesville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) FREDERICK (Last) HINZMAN

4. DATE OF DEATH (Month) Probably Jan. (Day) 28 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Single	1885	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Laborer		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William F. Hinzman	Louise Kunnal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		none	Frederick Hinzman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Undetermined - Body found about 3 days after death.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Epilepsy since boyhood

(c) Exposure -

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
no		

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Marsh,	Deputy Medical Examiner	Westminster Md	1-31-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	2-2-1949	Messiah Lutheran	Berrett, Carroll Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 1 1949	Edna M. Hewitt	C. M. Waltz	Winfield, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0342

491

CERTIFICATE OF DEATH 107

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): since 7-8-47
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Pr. Georges
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lanham
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) --- (Last) Holland

4. DATE OF DEATH: (Month) 1 (Day) 9 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 8-13-1885

9. AGE last birthday: 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Newark, N.J.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Holland

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown
(If year, give war or dates of service): -----

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	6 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	about 3 yrs

19a. DATE OF OPERATION: -----

19b. MAJOR FINDINGS OF OPERATION: -----

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

(CITY OR TOWN) (COUNTY) (STATE): ---

TIME OF INJURY (Month) (Day) (Year) (Hour): ----- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: ---

22. I hereby certify that I attended the deceased from Sept. 7, 1947, to Jan. 9, 1949, that I last saw the deceased alive on Jan. 9, 1949, and that death occurred at 4.05 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross (Degree or title) M.D. ADDRESS Sykesville, Md. DATE SIGNED 1-9-49

Martin Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Bur

DATE: Jan 11/49

NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cem

LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: Jan. 9, 1949

REGISTRAR'S SIGNATURE: Catharine Hall

24. FUNERAL DIRECTOR: The S. P. Hines Co

ADDRESS: 2901-14th St N W Washington

RECEIVED
JAN 11 1949
BUREAU V. S.

EVIDENCE FOR NOTATION IN ITEM #13 IS ON:
FILM No. G 119 MAR -7 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

156 ✓ 0343

CERTIFICATE OF DEATH 46f

Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge; LENGTH OF STAY 48 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge; STREET ADDRESS Broadway (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ELEK (Middle) — (Last) HORVATH

4. DATE OF DEATH: (Month) Jan. (Day) 16 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 23-1880

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Plant Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Horvath

14. MOTHER'S MAIDEN NAME: Frank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-1723

17. INFORMANT: Mrs. Lena Horvath

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Liver

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Primary site unknown

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 48, to Jan 16 49, that I last saw the deceased alive on Jan 15, 1949 and that death occurred at 11 A.m., from the causes and on the date stated above.

SIGNATURE H. H. Mason M.D. (Degree or title) ADDRESS Union Bridge DATE SIGNED Jan 18

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: Jan. 19-1949; NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery; LOCATION (City, town, or county) (State): Union Bridge, Md.

DATE REC'D BY LOCAL REG. Jan 19, 1949; REGISTRAR'S SIGNATURE Leslie A. Repp

24. FUNERAL DIRECTOR: D. D. Hartley & Sons; ADDRESS: Union Bridge & New Windsor, Md.

VS. A15

RECEIVED
JAN 21 1949
BUREAU V. S.

0344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

002

CERTIFICATE OF DEATH 134

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 2mos. 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockcrest, Mr Rockville
STREET ADDRESS (If rural give location): 906 Wade Ave.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Carrol (Last) Hunt

4. DATE OF DEATH: (Month) Jan. (Day) 29 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10/-/82.

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handyman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Henry Hunt

14. MOTHER'S MAIDEN NAME: Mary E. Hannah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If year, give war or dates of service) No

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Brother, Joseph Hunt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Active Pulmonary Tuberculosis — 2 mos. ~~Years~~

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with arteriosclerosis — 6 mos

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 18, 1948, to Jan. 29, 1949, that I last saw the deceased alive on Jan. 29, 1949, and that death occurred at 11:25 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph H. Marshall, M.D. Springfield State Hospital 1-29-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-1-49 — NAME OF CEMETERY OR CREMATORY: Hamilton Va. — LOCATION (City, town, or county) (State): Hamilton Va.

DATE REC'D BY LOCAL REG.: Jan. 30, 1949 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR — ADDRESS: Aubrey Hall - Purcellville, Va.

RECEIVED
FEB 1 1949
BUREAU V. S.

0345

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

592

CERTIFICATE OF DEATH 1315

Reg. Dist. No. 76

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
LENGTH OF STAY (in this place): 82 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5-8 Penna. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural, give location): 5-8 Penna. Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Henry	Hutting	Jan.	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
M	W	married	Dec. 25-1866	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk - Hotel Ret.		Carroll Co. Md.	U.S.A.

13. FATHER'S NAME: Jacob Henry Hutting
14. MOTHER'S MAIDEN NAME: ~~Barbara~~ Barbara Ellen Poulson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Florence Blair Hutting

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis (Acute) Syphilis (chr)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May, 1940, to Jan 11, 1949, that I last saw the deceased alive on Jan 10 -, 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. C. Jennette	MD.	Westminster Md	1-12-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan 13-1949	Bridge Cemetery	Westminster	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/13/49	[signature]	H Bankard & Son	Westminster

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

002 0346

19 Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 1 mo. 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 26,
STREET ADDRESS (If rural, give location): 3312 Tate Street ✓

3. NAME OF DECEASED (Type or Print): (First) Russell (Middle) Frank (Last) Johnson

4. DATE OF DEATH: (Month) January (Day) 10, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: June 23, 1926

9. AGE last birthday: 22 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Charlotte, N. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank R. Johnson

14. MOTHER'S MAIDEN NAME: Etta Shepherd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO. ✓

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval Between Onset and Death: July, 1947

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 26, 48 to Jan. 10, 19 49, that I last saw the deceased alive on Jan. 10, 19 49, and that death occurred at 10:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Wilson, M.D. ADDRESS: Henryton, Maryland DATE SIGNED: 1-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Jan 14-1949 NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery LOCATION (City, town, or county) (State): A. A. Co. Md

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE: Albert R. Snowden Deputy Local

24. FUNERAL DIRECTOR: Robert F. Williams ADDRESS: 1515 McElderry St

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 002 13b

0347

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll, [illegible] MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 23,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton Sanatorium	STREET ADDRESS (If rural, give location) 119 N. Schroeder Street

3. NAME OF DECEASED (Type or Print)	(First) FRANK	(Middle) NATHANIEL	(Last) JONES	4. DATE OF DEATH (Month) January (Day) 8, (Year) 1949
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 4, 1912	9. AGE last birthday 36 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Jones		14. MOTHER'S MAIDEN NAME Pearl Jones		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 215-09-3132	17. INFORMANT Mrs. Freddie B. Jones (Sister-in-law)		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Unknown
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 29, 1948, to Jan. 8, 1949, that I last saw the deceased alive on Jan. 8, 1949, and that death occurred at 5: A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman	M.D.	Henryton, Maryland	1-8-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/11/49	Mt Auburn	Balto	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-8-49	Albert R. Swanbham	Chas G. Cooper	512 Carrollton Ave.

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 11 1949
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0348

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton, LENGTH OF STAY (in this place) 1 Mr. 9 Mo. 27 Day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 9,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton Sanatorium	STREET ADDRESS (If rural, give location) 4648 Falls Road

3. NAME OF DECEASED (Type or Print)	(First) Irvin	(Middle) Eugene	(Last) Jones	4. DATE OF DEATH	(Month) January (Day) 23, (Year) 1949
5. SEX male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 30, 1911	9. AGE last birthday 37 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Stephen, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Eugene Jones	14. MOTHER'S MAIDEN NAME Ella Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 213-14-5991	17. INFORMANT Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	January
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	1947
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 24, 1947, to January 23, 1949, that I last saw the deceased alive on Jan. 23, 1949 and that death occurred at 10 p.m. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	January 23, 1949

23. BURIAL, CREMATION ~~REMOVAL~~ (Specify)	DATE 1/26/49	NAME OF CEMETERY OR CREMATORY Mt. Auburn	LOCATION (City, town, or county) (State) Salt Co. 30. Md
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE Albert R. Swanthand	24. FUNERAL DIRECTOR William A. Jackson	ADDRESS 916 Penna. Ave 1,

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JAN 25 1949
BUREAU V. S.

0349

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331 / 83a mtCB

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Arizona COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 32 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Phoenix
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.	STREET ADDRESS (If rural give location) unknown

3. NAME OF DECEASED (Type or Print) (First) Edith (Middle) (Last) Kent			4. DATE OF DEATH (Month) January, (Day) 16, (Year) 1949		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH ~~unknown~~ Abt. 1875	9. AGE last birthday 74 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Chadwick			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	6 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Cerebral hemorrhage	10 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Schizophrenia, hebephrenic type about	48 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-, 1942, to 1-15, 1949, that I last saw the deceased alive on 1-15, 1949, and that death occurred at 12.20 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Irene Holshman, M.D.	Springfield State Hospital	1-16-49

23. ~~BURIAL, CREMATION~~ REMOVAL ~~(Specify)~~	DATE Jan. 18 1949	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) Baltimore Md.
DATE REC'D BY LOCAL REG. Jan 18, 1949	REGISTRAR'S SIGNATURE C. Harry Weer	24. FUNERAL DIRECTOR H. W. Mears & Son, 805 N. Calvert St.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 21 1949
BUREAU V. S.

0350

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

331/830

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Virginia H. Lambert

3. (b) Social Security Number: None

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband ~~or wife~~: Albert E. Lambert

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug. 2 - 1866

8. AGE: Years: 82 Months: 4 Days: 30 If less than one day ... hrs. ... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles H. Haines
13. Birthplace: Maryland

MOTHER
14. Maiden name: Fransina Cook
15. Birthplace: Maryland

16. Informant: Frederick W. Lambert
Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan. 4 - 1949 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: D. D. Hartzler & Sons
Address: Union Bridge & New Windsor, Md.

19. Jany 3 1948 (Date rec'd by registrar) Orsino S. Bundel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1949 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1948 to Jan 1 1949 and that I last saw her alive on Dec 31 1948

Immediate cause of death: Cerebral hemorrhage

Due to: arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 1-2-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bur 422.1 0351

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH 93d Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 11 years, 9 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 4013 Fleetwood Avenue

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Lauf
4. DATE OF DEATH: (Month) January (Day) 9, (Year) 19 49

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1-30-1864
9. AGE last birthday: 84 yrs. If under 1 year: Months / Days / Hours / 24 hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin Lippert
14. MOTHER'S MAIDEN NAME: Anna Raedel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic myocarditis and myocardial degeneration — 6 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Generalized arteriosclerosis — about 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type — about 20 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-, 19 42, to 1-8, 19 49, that I last saw the deceased alive on 1-8-, 19 49, and that death occurred at 8.10 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Irene L. Workman, M.D. ADDRESS: Springfield State Hospital DATE SIGNED: 1-9-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE: 1/12/49
NAME OF CEMETERY OR CREMATORY: Parkwood
LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: 1/10/49
REGISTRAR'S SIGNATURE: A.W. Hedrick
24. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS: 7401 Belair Rd.

M — The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0352

331

CERTIFICATE OF DEATH

83a Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 14 yrs 6 mo 3 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Fredrick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fredrick.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) (Last) Linton

4. DATE OF DEATH (Month) Jan (Day) 12th (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED? (Specify) single

8. DATE OF BIRTH 1909

9. AGE last birthday 39 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent

10b. KIND OF BUSINESS OR INDUSTRY ✓

11. BIRTHPLACE (State or foreign country) Fredrick

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles Linton

14. MOTHER'S MAIDEN NAME Ada Gilbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If year, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT Mrs Russell Harris.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Terminal Pneumonia	2 da
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Hemorrhage	2 wks
	(c) Epilepsy	30 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ✓

19b. MAJOR FINDINGS OF OPERATION ✓

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from June 18, 1934, to Jan 12, 1949, that I last saw the deceased alive on Jan 12, 1949, and that death occurred at 3-30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. J. Martin MD ADDRESS Sykesville Md DATE SIGNED 1/12/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-15-49
NAME OF CEMETERY OR CREMATORY Brook Hill Cemetery
LOCATION (City, town, or county) (State) Yellow Springs, Md.

DATE REC'D BY LOCAL REG. Jan. 13, 1949
REGISTRAR'S SIGNATURE A Harry Weer

24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Md.

RECEIVED
JAN 17 1949
BUREAU T. S.

0353

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1
94a

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 4
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Harvey James Lockard

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bessie Beaver

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): June 21, 1883

8. AGE:

Years	Months	Days	If less than one day
65	6	13	..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: School bus driver

11. Industry or business:

FATHER
12. Name: Joshua Lockard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Lambert
15. Birthplace: Maryland

16. Informant: Mrs. H. J. Lockard
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1/6/49 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/3 1949 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1949 at 6½ a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26th 1948, to January 3rd 1949 and that I last saw him alive on January 2nd 1949

Immediate cause of death: Acute Coronary Thrombosis — DURATION: 20 minutes

Due to: Chronic Arteriosclerosis — 5 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] (M.D.) M. D. or other

Address: Westminster, Md. Date signed: 1/3/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 5 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 422.2 93d

0354

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) since 6/18/07	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural, give location) 1851 S. Charles Street

3. NAME OF DECEASED (Type or Print)	(First) Harry	(Middle) -	(Last) Long	4. DATE OF DEATH	(Month) January (Day) 6 (Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 1889 ?	9. AGE last birthday 59 ? yrs.	If under 1 year Months - Days - If under 24 hrs. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Francis Long	14. MOTHER'S MAIDEN NAME Annie Upton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) no	16. SOCIAL SECURITY No. unknown	17. INFORMANT Records of Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial degeneration	1½ months
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) /	
	(c) /	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Mental deficiency	55 years

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Jan. 6, 1949, that I last saw the deceased alive on Jan. 6, 1949, and that death occurred at 3:52 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Gross, M. D.	Resident Physician	Sykesville, Maryland	1-6-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 12, 1949	Springfield Hospital Cem.	Sykesville Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 11, 1949	C Harry Weer	C Harry Weer	Sykesville Md.

RECEIVED
JAN 13 1949
BUREAU V. S.

0355

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

163
47d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH · COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (in this place) 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) Fields (Last) Moore

4. DATE OF DEATH (Month) Jan. (Day) 19 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Oct. 22-1877
9. AGE last birthday 71-1-27 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector
10b. KIND OF BUSINESS OR INDUSTRY Congoleum-Nairn
11. BIRTHPLACE (State or foreign country) La-Grange N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jerry Fields
14. MOTHER'S MAIDEN NAME Emma Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 218-10-0010
17. INFORMANT Mrs L. B. Spencer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of L lung.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 28, 1948, to Jan 19, 1949, that I last saw the deceased alive on Jan 19, 1949, and that death occurred at 2.05 P m., from the causes and on the date stated above.

SIGNATURE W. C. Jennette (Degree or title) MD. ADDRESS Westminster Md DATE SIGNED 1-19-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 22-1949
NAME OF CEMETERY OR CREMATORY La-Grange
LOCATION (City, town, or county) N. Carolina (State)

DATE REC'D BY LOCAL REG. 1/19/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR H Bankard Ison ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 24 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0356

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY Carroll, [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 8 mo., 23 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 2,
STREET ADDRESS (If rural, give location) 413 E. Lafayette Avenue

3. NAME OF DECEASED (Type or Print): (First) LOUISE (Middle) (Last) PAULEY

4. DATE OF DEATH: (Month) January (Day) 13, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 11-16-'27

9. AGE last birthday: 21 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Myrtlewood, Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard James Pauley

14. MOTHER'S MAIDEN NAME: Bertha Earl Irvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 421-20-7652

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: May 15, 1947

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 20, 1949, to Jan. 13, 1949, that I last saw the deceased alive on Jan. 13, 1949, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Reuben Hoffman, M.D. Henryton, Maryland 1-13-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 1/20/49 | NAME OF CEMETERY OR CREMATORY: Evans | LOCATION (City, town, or county) (State): Myrtlewood, Ala.

DATE REC'D BY LOCAL REG.: Jan. 13,'49 | REGISTRAR'S SIGNATURE: Albert R. [illegible] | 24. FUNERAL DIRECTOR ADDRESS: William A Jackson 916 Penna Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

0357

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton, Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17,
STREET ADDRESS (If rural, give location): 1239-Myrtle Ave.,

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) Mae (Last) Porter

4. DATE OF DEATH: (Month) January (Day) 12, (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 11, 1926

9. AGE last birthday: 22 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Halifax, N. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Miles Brown

14. MOTHER'S MAIDEN NAME: Olivia Lemons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 239-32-4864

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: December

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — 1947

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1948, to Jan. 12, 1949, that I last saw the deceased alive on Jan. 12, 1949, and that death occurred at 7:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. — ADDRESS: Roanoke Rapids, N.C. — DATE SIGNED: 1-12-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1/15/1949 — NAME OF CEMETERY OR CREMATORY: Calvary — LOCATION (City, town, or county) (State): Westminster, Md.

DATE REC'D BY LOCAL REG. 1-12-49 — REGISTRAR'S SIGNATURE: Albert R. Brashears Deputy Local — 24. FUNERAL DIRECTOR: C. A. Hafer — ADDRESS: 98 Main St. Reisterstown

RECEIVED
JAN 14 1949
BUREAU V. S.

0358

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

442
131a

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead – Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry F Richards

3. (b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W.

6.(b) Name of ~~Husband~~ or wife Mary C. Grose

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19–1869

8. AGE:

Years	Months	Days	If less than one day
79	9	14	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name George C Richards
13. Birthplace Maryland

MOTHER
14. Maiden name Alice Mummaugh
15. Birthplace Md

16. Informant Miss Emma Richards
Address Hampstead Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan 5/49
(month) (day) (year)

Cemetery or crematory Hampstead

Location Carroll co Md

18. Funeral director Edw C Tipton
Address Hampstead Md

19. Jan. 3 1949 John S. Hughes Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3, 1949 at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30, 1948 to Jan. 3, 1948 and that I last saw him alive on Dec. 30, 1948

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs
Due to Hypertension Cardio	
Renal Vascular disease	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edgar M. Bush M. D. ~~or other~~

Address Hampstead Md. Date signed 1/3/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 5 1949
BUREAU V. S.

0359

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

002
30b

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Sykesville — LENGTH OF STAY (in this place) 19 yrs. 9 mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) 519 N. Mulberry Street

3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) PHILIP	(Last) RIGGLEMAN	4. DATE OF DEATH	(Month) 1	(Day) 28	(Year) 1949
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 7/23/05	9. AGE last birthday 43 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Hand		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Riggleman			14. MOTHER'S MAIDEN NAME Bessie Richter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No. none	17. INFORMANT Record, Springfield State Hospital				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary tuberculosis	2 mos.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with syphilitic meningo-encephalitis	20 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/6, 1948, to 1/28, 1949, that I last saw the deceased alive on 1/28, 1949, and that death occurred at 6:50 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Joseph H. Marshall	M. D.	Springfield State Hospital	1/28/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	1/31/49	Rose Hill Cent	Hagerstown Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 29, 1949	C. Harry Weer	R. K. Coffman	Hagerstown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 31 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0360

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton,; LENGTH OF STAY (in this place) 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 5,; STREET ADDRESS (If rural, give location) 1814 Orleans Street

3. NAME OF DECEASED (Type or Print): (First) Elizabeth; (Middle); (Last) Rogers

4. DATE OF DEATH: (Month) January; (Day) 9,; (Year) 1949

5. SEX: female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 26, 1918

9. AGE last birthday: 30 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Chester, County S.Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Muliues Lyles

14. MOTHER'S MAIDEN NAME: Margaret Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Miss Irene Williams (Aunt)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 7, 1949 to January 9 1949, that I last saw the deceased alive on January 9, 1949 and that death occurred at 9:40 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Reuben Hoffman, M.D. Henryton, Maryland January 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Jan. 12-49

NAME OF CEMETERY OR CREMATORY Arbutus mem. Park

LOCATION (City, town, or county) Arbutus md (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Albert R. Swanbham

24. FUNERAL DIRECTOR Elroy O. Wilson

ADDRESS 1000 Bantley ave

Deputy Local

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

002 / 13b

0361

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore-2
(If outside city or town limits, write RURAL and give nearest town)

Street No. 824-Greemount Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Joseph Henry Rogers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widowed

6.(b) Name of husband or wife Naomi Rogers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 25, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	8	..... hrs. ..... min.

9. Birthplace Oxford, N. Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Henry Rogers
13. Birthplace Oxford, N. Carolina

MOTHER
14. Maiden name Malinda Mitchell
15. Birthplace Oxford, N. Carolina

16. Informant Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/4/49 (month) (day) (year)

Cemetery or crematory Morgue

Location Baltimore Maryland

18. Funeral director Mrs Samuel E. Hemsly

Address 578 W. Biddle Street

19. January 2, 1949 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1949, at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1948, to January 2, 1949 and that I last saw him alive on January 2, 1949

Immediate cause of death	DURATION
Pulmonary Tuberculosis	October 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 1-2-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

003 131

0362

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 4 m. 6 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs. 4 m. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Middletown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Ernest Shafer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4/26/91

8. AGE: Years	Months	Days	If less than one day
57	8	8	hrs. min.

9. Birthplace: Frederick County, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Charles W. Shafer

13. Birthplace: Frederick County

MOTHER — 14. Maiden name: Ora Ramsburg

15. Birthplace: Frederick County

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-6-49 (month) (day) (year)

Cemetery or crematory: Lutheran Cem.

Location: Middletown, Md.

18. Funeral director: Gladhill Bro.

Address: Middletown, Md.

19. Jan. 4 1949 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3, 1949 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/27 1946, to Jan. 3, 1949 and that I last saw him alive on Jan. 3, 1949

Immediate cause of death	DURATION
Pulmonary tuberculosis	2½ yrs
Due to	
Due to	
Other conditions: Schizophrenia, Hebephrenic type (Include pregnancy within 3 months of death)	17 yrs

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall M.D. M. D. or other

Address: Springfield State Hospital Date signed: 1/4/49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0363

610

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 79

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Detour
MARYLAND
LENGTH OF STAY (in this place): 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Detour
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) FREDERICK (Middle) JEROME (Last) SHORB

4. DATE OF DEATH: (Month) Jan. (Day) 20 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 6-7-1854

9. AGE last birthday: 94 yrs. If under 1 year: Months 6, Days 13, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Merchant

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Shorb

14. MOTHER'S MAIDEN NAME: Mary Dutrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Vallie M. Shorb, Detour, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH: 3 days

Immediate cause (a) Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertrophy of prostate gland

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis; arteriosclerosis

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 20, 1949, to Jan. 20, 1949, that I last saw the deceased alive on Jan. 20, 1949, and that death occurred at 11:45 A. m., from the causes and on the date stated above.

SIGNATURE: M. Franklin Pinkey (Degree or title) MD ADDRESS: Thurmont, Md. DATE SIGNED: Jan. 21, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 1-23-1949
NAME OF CEMETERY OR CREMATORY: Haugh's
LOCATION (City, town, or county) (State): Ladiesburg, Fred. Md.

DATE REC'D BY LOCAL REG.: Jan. 23, 1949
REGISTRAR'S SIGNATURE: Fanny M. Powell

24. FUNERAL DIRECTOR ADDRESS: M. L. Creager & Son, Thurmont, Md

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JAN 25 1949
BUREAU U. S.

0364

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450.0

CERTIFICATE OF DEATH

97 Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (In this place): since 12/29/35	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Boonsboro
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) Ray	(Last) SINNISEN	4. DATE OF DEATH	(Month) January (Day) 26 (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 1/12/78	9. AGE last birthday: 71 yrs.	If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm hand	10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (State or foreign country): Allegany County, Maryland	12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME: Geary Sinnisen	14. MOTHER'S MAIDEN NAME: ? Finfrock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unkn. (If year, give war or dates of service): —	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Records of Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arteriosclerosis	14 yrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Traumatic Psychosis	14 yrs.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —	(CITY OR TOWN) (COUNTY) (STATE): —
TIME OF INJURY (Month) (Day) (Year) (Hour): — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Jan. 26, 1949, that I last saw the deceased alive on January 26, 1949, and that death occurred at 11:53 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Gross, M.D.	Martin Gross, M.D.	Sykesville, Maryland	1/26/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE: Jan. 29, 1949	NAME OF CEMETERY OR CREMATORY: Boonsboro	LOCATION (City, town, or county): Frederick Co. (State): Md.
DATE REC'D BY LOCAL REG.: Jan 26, 1949	REGISTRAR'S SIGNATURE: C Harry Weer	24. FUNERAL DIRECTOR: Wm. F. Bast & Son, Boonsboro, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 31 1949
BUREAU V. S.

0365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 16 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, 2,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henrton, Sanatorium, Henryton	STREET ADDRESS (If rural, give location) 12-N. Exeter Street

3. NAME OF DECEASED (Type or Print) (First) Andrew	(Middle) James	(Last) Smith	4. DATE OF DEATH (Month) Jan.,	(Day) 30, (Year) 1949
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan., 7, 1910	9. AGE last birthday 39 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Richmond, Va.,	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Smith		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 226-20-1956	17. INFORMANT Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Dec., 1947

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 14 1949, to Jan., 30 1949, that I last saw the deceased alive on Jan., 30, 1949, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

SIGNATURE Reuben Hoffman (Degree or title) M.D. ADDRESS Henryton, Maryland DATE SIGNED Jan., 30, 1949

23. [redacted] REMOVAL (Specify)	DATE 2/2/49	NAME OF CEMETERY OR CREMATORY City Morgue	LOCATION (City, town, or county) (State) Baltimore Maryland
DATE REC'D BY LOCAL REG. 1-30-49	REGISTRAR'S SIGNATURE Albert R. Swanhaus Deputy Local	24. FUNERAL DIRECTOR Mrs Samuel T. Hemsley	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 3 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0366

450.0
131a

CERTIFICATE OF DEATH

Reg. Dist. No. 82

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeville
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeville
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) David (Middle) A. (Last) Snyder

4. DATE OF DEATH: (Month) January (Day) 29 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 25, 1862

9. AGE last birthday: 86 yrs. If under 1 year: Months 8 Days 4 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Theodore Snyder

14. MOTHER'S MAIDEN NAME: Sarah Moxley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: H. M. Snyder. Mt.Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a) Uremia (Chr.)	due to	3 mo
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Interstitial Nephritis	due to	? yrs
	(c) Advanced Arterio-sclerosis		? yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to Jan. 29, 1949, that I last saw the deceased alive on Jan. 28, 1949, and that death occurred at 8:32 A. m., from the causes and on the date stated above.

SIGNATURE: Stanley Grabill (Degree or title) ADDRESS: Mt. Airy, Maryland DATE SIGNED: 1/29/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb. 1. 49

NAME OF CEMETERY OR CREMATORY: Frederick Memorial

LOCATION (City, town, or county) (State): Frederick, Md.

DATE RECD BY LOCAL REG.: 1/31/49

REGISTRAR'S SIGNATURE: Wm D Snyder

24. FUNERAL DIRECTOR: Olin L. Molesworth ADDRESS: Damascus, Md.

RECEIVED
FEB 1 1949
BUREAU V. S.

0367

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1

CERTIFICATE OF DEATH

92d Reg. Dist. No. 76

1. PLACE OF DEATH· COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster #6 — LENGTH OF STAY (in this place) 83-4-23-	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster #6
HOSPITAL OR INSTITUTION OR STREET ADDRESS same	STREET ADDRESS (If rural, give location) same Jan. 9, 1949

3. NAME OF DECEASED (Type or Print)	(First) Adam	(Middle) Edward	(Last) Stater	4. DATE OF DEATH (Month) Jan. (Day) 9, (Year) 1949
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH August 14-1865	9. AGE last birthday 83 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Stater		14. MOTHER'S MAIDEN NAME Anna Wonders		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT Sterling J. Stater, Westminster 6, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — 15 min

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis (General) C̄ — 5 yrs.

(c) Myocardial degeneration & Valvular Insufficiency

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 1948, to January 9 1949, that I last saw the deceased ~~alive~~ dead on January 9, 1949, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A Glenn Speicher	M.D.	Westminster Md	1/10/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 13, 1949	Deer Park Cemetery	Smallwood Carroll Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/12/49	[signature]	H Bankard & Son	Westminster, Md.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0368

450.0

CERTIFICATE OF DEATH 131a

Reg. Dist. No. 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Medford
MARYLAND — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Medford
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Typa or Print): (First) Ella (Middle) Mae (Last) Stultz

4. DATE OF DEATH: (Month) Jan (Day) 18 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Aug 8-1872

9. AGE last birthday: 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Giva kind of work done during most of working lifa, aven if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll County, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sylvester Baker

14. MOTHER'S MAIDEN NAME: Susan Bussard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT: Grosler E Stultz

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) acute cardiac decompensation	10 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause atating the underlying cause last	(b) chronic interstitial Nephritis	3 yrs
	(c) Arteria sclerosis	5-7 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1949 to Jan 18, 1949 that I last saw the deceased alive on Jan 18, 1949 and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas. R Foutz MD — ADDRESS: Westminster Md — DATE SIGNED: Jan 20-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan 21-1949 — NAME OF CEMETERY OR CREMATORY: Methodist Cemetery — LOCATION (City, town, or county) (State): Uniontown, Maryland

DATE REC'D BY LOCAL REG.: Jan 21-1949 — REGISTRAR'S SIGNATURE: Erwin S Bimdil

24. FUNERAL DIRECTOR — ADDRESS: D D Hartzler & Sons, Union Bridge & New Windsor, Maryland

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JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

174 48 ✓ 0369

Reg. Dist. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-- Sykesville
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural--Sykesville
STREET ADDRESS (If rural give location) Dorsey's Crossroads

3. NAME OF DECEASED (Type or Print): (First) OMIE (Middle) (Last) TYLER

4. DATE OF DEATH: (Month) Jan. (Day) 14 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 8, 1889

9. AGE last birthday: 59 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Lon ~~Tyler~~ Hunt

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: William D. Tyler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinomatosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of uterus

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/13/, 1949, to 1/14/, 1949, that I last saw the deceased alive on 1/14/, 1949, and that death occurred at 5:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm E. Martin M.D Randallstown, Md

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): Burial — DATE: Jan. 18, 1949 — NAME OF CEMETERY ~~OR CREMATORY~~: Mt. Zion — LOCATION (City, town, or county) (State): Loudon Co. Tenn.

DATE REC'D BY LOCAL REG. Jan 15 1949 — REGISTRAR'S SIGNATURE Edna M. Hewitt

24. FUNERAL DIRECTOR: C.M Waltz — ADDRESS: Winfield, Md.

VS. A15

RECEIVED
FEB 11 1949
BUREAU V. S.

0370

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

443x
131a

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural-- Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural-- Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: CORA MAE WARD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: C. Bradley Ward
deceased

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 28, 1879

8. AGE:

Years	Months	Days	If less than one day
69	6	7	... hrs. ... min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John Shaeffer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lydia Arbaugh
15. Birthplace: Maryland

16. Informant: Mrs. Frank Baber
Address: Sykesville, Md.

17. Burial
(Burial, ~~cremation, or removal. Which?~~)
Date thereof: 1-8-1949 (month) (day) (year)

Cemetery ~~or crematory~~: Kriders

Location: Westminster, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Jan. 7 1949 (Date rec'd by registrar) Harry Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1949, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19..., to death 19...

and that I last saw her alive on January 5-1949 19...

Immediate cause of death: hypertensive cardiovascular disease with myocarditis & chronic interstitial nephritis

Due to: senile changes

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Wm Lawson M.D.
M. D. or other

Address: Sykesville, Md Date signed 1/5/49.

VS A15 (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU V. S.

0371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

420.0
793d

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Finksburg, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: James Alexander Wentz

3.(b) Social Security Number: 213-14-4741

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Emma Fahrney Wentz

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb. 1 - 1865

8. AGE: Years: 83 | Months: 11 | Days: 18 | If less than one day: ... hrs. ... min.

9. Birthplace: York County, Pa.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER

12. Name: John Henry

13. Birthplace: York Co. Pa.

MOTHER

14. Maiden name: Sophia Kline

15. Birthplace: Frederick Co. Md.

16. Informant: Emma Fahrney Wentz

Address: Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1949 (month) (day) (year)

Cemetery or crematory: Lazarus Union Church

Location: Finksburg. Md

18. Funeral director: H. C. Gerlach

Address: Glen Rock. Pa.

19. Jan. 19 1949 (Date rec'd by registrar) Mrs. W. P. S. Deaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1949 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1949 to Jan 18 1949 and that I last saw h/M alive on Jan 18 1949

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to: Arteriosclerotic Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. H. Foard M. D. or other

Address: Manchester Date signed: Jan 18-1949

RECEIVED
JAN 21 1949
BUREAU V. S.

0372

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

002
13b

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 11 mo., 29days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Landover
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton Sanatorium, He	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) CATHERINE	(Middle) —	(Last) WHITE	4. DATE OF DEATH (Month) Jan., (Day) 26, (Year) 1949
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 17,1919	9. AGE last birthday 29 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Prince George, Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Henry White		14. MOTHER'S MAIDEN NAME Lizzie Deal		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	June
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	1946
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 28 1948, to Jan., 26, 1949 that I last saw the deceased alive on Jan., 26, 1949 and that death occurred at 7:05 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	Jan. 29, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE Jan. 28, 1949	NAME OF CEMETERY OR CREMATORY Woodmore Catholic Cemetery	LOCATION (City, town, or county) (State) Prince George County, Md.
DATE REC'D BY LOCAL REG 1-26-49	REGISTRAR'S SIGNATURE Albert R. Swankhaus Deputy Local	24. FUNERAL DIRECTOR Henry S. Washington & Sons	ADDRESS 467 N. st. N.W. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 29 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1

0373

CERTIFICATE OF DEATH

130

Reg. Dist. No. 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
LENGTH OF STAY (in this place) 1 yr. 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural, give location) Frederick St.

3. NAME OF DECEASED (Type or Print): (First) DR. FREDERICK (Middle) JULIUS (Last) WILKENS

4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1949

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct. 29. 1876

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MEDICAL DOCTOR

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frederick Wilkens

14. MOTHER'S MAIDEN NAME: Henrietta Ripplemeir

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Dr. E. Reese Wilkens, Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardio-Vascular disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Tuberculosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/19, 1949, to 1/24, 1949, that I last saw the deceased alive on 1/19, 1949, and that death occurred at 10 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Merritt E. Robertson M.D. New Windsor, Md. 1/24/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Jan 26 '49 NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery LOCATION (City, town, or county) (State): Baltimore Md.

DATE REC'D BY LOCAL REG.: Jan 26 1949 REGISTRAR'S SIGNATURE: Emma L Benedict

24. FUNERAL DIRECTOR: J. E. Myers Jr. ADDRESS: Westminster Md.

RECEIVED
JAN 26 1949
BUREAU V. S.

0374

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

002
13b

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1 mo., 16 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cecilton
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton Sanatorium	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) JUSTEEN	(Middle) EVELYN	(Last) WISE	4. DATE OF DEATH	(Month) Jan. (Day) 8, (Year) 1949
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: July 21, 1927	9. AGE last birthday: 21 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Cecilton, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: James Wise	14. MOTHER'S MAIDEN NAME: Anna Brooks				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: 214-26-1450	17. INFORMANT: Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Sept. 1948
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 22, 1948, to Jan. 8, 1949, that I last saw the deceased alive on Jan. 8, 1949, and that death occurred at 4:30A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	1-8-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: January 12, '49	NAME OF CEMETERY OR CREMATORY: Cecilton,	LOCATION (City, town, or county) (State): Cecilton, Maryland
DATE REC'D BY LOCAL REG. 1-8-49	REGISTRAR'S SIGNATURE: Albert R. Swanthan	24. FUNERAL DIRECTOR: Joseph A. Livley	ADDRESS: 661 Barre St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

422.1 Bc

0375

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A16 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2821 Greenland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Max Emil Zimmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Louise A. Schuman

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1885

8. AGE: Years	Months	Days	If less than one day
63	11	11	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Chef

11. Industry or business:

FATHER

12. Name: Emil Zimmer

13. Birthplace: Germany

MOTHER

14. Maiden name: Marie Louise Z

15. Birthplace: Germany

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-49 (month) (day) (year)

Cemetery or crematory: Maryland Memorial Park

Location: Balto. - Md.

18. Funeral director: Howard J. Rees

Address: 5305 Harford Rd. Balto. Md.

19. Jan. 6 1949 (Date rec'd by registrar) C. Harry Rees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2, 1949 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23, 1948 to Jan. 2, 1949 and that I last saw him alive on Jan. 2, 1949

	DURATION
Immediate cause of death: Cerebral vascular accident	2 days
Due to: Generalized arteriosclerosis	
Due to: Myocardial degeneration	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, Md. M. D. or other

Address: Springfield State Hospital Date signed 1-2-49

RECEIVED
JAN 4 1949
BUREAU V. S.